## Alcohol Matrix cell C3: Management/supervision; Medical treatment

S Seminal studies | K Key studies | R Reviews | G Guidance | MORE Search for more studies

S Organisational factors affect training impact (1980). English study including doctors and nurses found that without the opportunity to gain further experience in working with problem drinkers and the support of experienced colleagues, the effects of training are less and less well sustained.

S Listening management transforms alcohol clinic (1970). Remarkable series of US studies from the late 1950s proved that an alcohol clinic's intake and attendance can be transformed by a management which listened to the patients and systematically ensured they were treated with warmth and respect. More in this slide presentation and video, which end by focusing on the studies.

S Some counsellors inspire retention, others rapid drop-out (1976). Turning the spotlight on recruitment, at a US alcohol treatment clinic trainee counsellors differed greatly in patient retention. Neither experience of alcoholism treatment nor further on-the-job training greatly affected performance.

S Interpersonal functioning can be measured (1981). US study in a hospital alcohol clinic used a simple written method to score the therapy-related social skills of counsellors, which were strongly related to their patients' post-treatment relapse.

K How to identify rapport- and retention- generating counsellors (2002). Replication of above seminal study at a Finnish outpatient alcohol clinic used the same system to identify which counsellors would generate the mutual client/counsellor rapport associated with retention.

K Receptive trainees make training work (2004). US study at medical centre addictions programme suggests that recruiting the 'right' clinicians who have not been trained in motivational interviewing would be better than choosing the 'wrong' ones who have been, and the former gain most from training.

K Stepping up intensity of care does not help (1999). From Canada the first evaluation of 'stepped care' for heavy drinkers found no added benefit from offering further treatment only to those who did not respond to initial therapy, but the study was not a definitive refutation of this cost-saving strategy.

R Implementation strategies ([Australian] National Centre for Education and Training on Addiction, 2008). Lessons from health promotion and medical care on how to improve addiction treatment practice by introducing research-based innovations, including common medical education and training strategies.

G What counts as competence in treatment staff? ([UK] Skills for Justice, regularly updated). Competence criteria and training and learning opportunities for substance use specialists in the health and social care sectors, collated by Skills for Justice, a charity licensed by government to support employers to develop and sustain a skilled workforce.

G Staff development toolkit ([UK] National Treatment Agency for Substance Misuse, 2003).

G NICE advises stepped care ([UK] National Institute for Health and Clinical Excellence, 2011). Endorses trying the least intensive potentially appropriate treatment and only 'stepping up' to more intensive and costly approaches if the initial attempt does not work.

G Models of care for alcohol misusers ([UK] Department of Health and National Treatment Agency for Substance Misuse, 2006). Includes (from page 74) quality criteria for managing alcohol services.

G US patient placement criteria (American Society of Addiction Medicine, 2013). Most widely used system for determining the intensity and level of care needed for an individual patient. Supplement focuses on medication-based treatments for alcohol use problems.

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For subtopics go to the subject search page.

**Matrix Bite** a commentary on this cell from the cell-by-cell Matrix Bites course

**Click underlined text to highlight text/link in cell**

**What is this cell about?** About the treatment of alcohol dependence in a medical context and/or involving medical care. Medications are the main distinguishing feature, but often they are prescribed only to a minority and treatment entails potentially therapeutic interactions with clinical and other staff. All these processes are themselves affected by the management functions of selecting, training and managing staff, and managing the intervention programme. In highly controlled studies, it may be possible to divorce the impact of interventions from the management of the service delivering them, but in everyday practice, whether interventions get adopted and adequately implemented, and whether staff (see cell B3) are able to develop and maintain appropriate attitudes and knowledge, depend on management and supervision.

**Where should I start?** As a manager, one starting point is to know what your staff should be able to do and then to look for ways to find and develop those competencies. For both tasks, the Herculean efforts of the Skills for Justice team will shortcut your access to relevant nationally accepted standards and training and education opportunities to help your staff reach those standards. The link we have given is for substance misuse specialists in health and social care, but you can explore the site for similar information in respect of non-specialists and other sectors. Having identified the required competencies, you can then use the Drug and Alcohol Findings Effectiveness Bank or other services to find research on how best to sustain and develop these competencies in your staff.

**Highlighted study** In one of our Manners Matter reviews we pointed argued that managements and services which care about the human qualities which cement relationships will also care enough to be organised and persistent about embedding these in routine practice. One of the best examples was the transformation brought about at Massachusetts General Hospital's alcohol clinic by a new management, whose starting point was to listen to the patients rather than to dismiss them as helpless alcoholics who neither wanted nor deserved help. Then they systematically and persistently instilled the resultant attitudes and understandings across the hospital's contact points with the patients and removed barriers to engagement with treatment. The result was to engage a far higher proportion of alcoholics identified at the hospital. From being treatment-resistant cases who did not want help, they become as 'engageable' as the typical psychiatric patient.

### Issues to think about

▸ How *do* you identify the right people? In cell C2 we suggested that recruitment was the critical missing link because people with desired attitudes and ways of relating start off as more effective counsellors and also benefit more from training. But how can you identify them? In a seminal US study it was on the basis of counsellors' written responses to several written scenarios intended to approximate real interactions between counsellors and patients or patients' relatives. Responses were rated for empathy, genuineness, respect for the client, and the ability to be specific and direct in expression of feelings and experiences. The higher the combined score, the less likely patients of those counsellors were to relapse over the next two years. The same method was found to transfer to another country and a non-residential treatment setting, where higher ratings were linked to better rapport between client and counsellor and longer stays in treatment. How would you weight results of tests like these compared to conventional recruitment criteria like extent and relevance of qualifications and experience?

▸ Start small (and cheap) and build up if needed? That was the advice offered by NICE, Britain's health intervention assessors. In this they were endorsing recommendations from the National Treatment Agency for Substance Misuse (then responsible for promoting addiction treatment in England) that new patients "should be assessed, and initially receive the least intensive or least prolonged intervention considered suitable for the level of need and complexity identified. If response ... is inadequate, a more intensive or prolonged package

of care may be needed". Intuitively this 'makes sense', but a weak link is whether intensifying treatment really will help when less intensive interventions have failed. The only direct test we know of came from Canada, where problem drinkers randomly assigned to stepped care attended more sessions but in terms of their drinking, did no better than those left in the basic treatment, even if they were still drinking heavily. For stepped care the worst explanation is that clients resistant to initial treatment largely continue to be so even when intensity is stepped up, making this merely a further waste of resources. Given the limitations of the study, this would be a premature verdict. But from the Matrix Bite for cell A2 we also know (see Highlighted study) that patients assumed to need extended care can on average do just as well if offered or if they accept only very brief treatment. Is this a case of lack of adequate research resulting in there being little evidence for an obviously sensible approach, or of what seems obvious failing in reality?

**Close Matrix Bite**

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